Introduction

Definition

Targeted Case Management (TCM) is an intervention which assures that service systems and community supports are maximally responsive to the specific, multiple, and changing needs of individual children and their families. The case manager within the context of this program has a limited caseload, works a flexible schedule, is viewed as an equal in the treatment and focuses on strengths as opposed to deficits.

Purpose

Targeted Case Management is brokering service in that its purpose is to assist eligible children, youth and their families in gaining access to needed psychiatric and psychological treatment, medical, social, educational, vocational and other supports essential to maximizing the child or youth's adjustment and functioning within a family setting and the community.

In summary, Targeted Case Management will: 1) ensure continuity of care, 2) ensure that services will be responsive to the person's full range of needs as they change over time, 3) help individuals overcome obstacles and gain access to services, and 4) ensure that services match the individual and family's needs.

Division Philosophy for Targeted Case Management

The Division of Comprehensive Psychiatric Services' philosophy of Targeted Case Management embraces the following assumptions and principles:

1. Targeted Case Management is a necessary service for the majority of children with serious emotional disturbance. It is also a necessary service for certain children experiencing an Acute Psychiatric Condition. ITCM enhances individual access to an array of mental health treatment services in addition to provision of advocacy and active support for a child and the family;

2. The focus of Targeted Case Management is on the individual child and family strengths;'

3. The relationship between the Targeted Case Manager and the child and family is primary and essential to effectively support the child to achieve agreed upon outcomes within the identified domains of the child's life;

4. Services and supports are responsive to the unique needs and potentials of each child, are sensitive to the child and family's community, ethnic and cultural context, and guided by an individualized treatment plan;

5. Supports and services are most effective and functional when occurring within the least restrictive , most normative environment that is clinically appropriate;

6. The community is viewed as rich with resources and natural community supports are utilized whenever possible. These resources and supports are delivered in a coordinated manner such that the child can move through the system of services in accordance with their changing needs;

7. Professional interaction with the child/family should focus on the child's potential for improvement and growth, the family's role as full participants in service planning, and on improving the quality of everyday life.

Target Population

Eligible Recipients

Children and youth from the public mental health system, 0 through 20 years of age, who have a DSM IV diagnosis, excluding a primary diagnosis of developmental disability or substance abuse, and meet the state definitions for Serious Emotional Disturbance or Acute Psychiatric Condition. Priority consideration for TCM should be considered for:

1. Children and adolescents admitted to a DMH psychiatric inpatient facility, DMH licensed residential program, Treatment Family Home Program, or intensive day treatment;

2. Children and adolescents from the public mental health system on a waiting list for DMH funded psychiatric inpatient or residential placement;

3. Children who are homeless.

Program Description

Service Activities

The following service activities of TCM are billable components, when provided on behalf of a child and documented as relating to their individualized service plan:

1. Arrangement, coordination and participation in the assessment to ensure that all areas of the child's and family's life are assessed to determine unique strengths and needs;

    a. Arrangement and coordination of an individualized treatment plan (ITP) encompassing all areas of the child's life development including specific outcomes with varied goals, service and support needs, and person(s) responsible. Note that the

ITP reflects the specific supports that the TCM will be responsible for arranging or putting into place to help the child succeed in the family setting and community;

b. Participation in the Child and Family Interagency Team as well as any relevant interdisciplinary teams to assure continuity and coordination of service delivery to individual children, youth and their families.

c. Participation in treatment and service plan development while child is receiving services from psychiatric inpatient, residential facility or treatment family home. The purpose of this involvement is to oversee the transition process and coordinate the community-based services as the child accesses the options available in the system of care;

d. Conduct periodic reassessment of child's status, service choices available, overall community functioning, strengths, preferences, needs and progress toward defined outcomes.

2. Coordination of the service plan implementation, including linking individuals and families to services, arranging the supports necessary to access resources and facilitating communication between service partners;

   a. Advocate on behalf of an individual and family to obtain the quality and quantity of services to which the individual is entitled;

   b. Locate qualified service providers and community resources to provide the services and supports specified by the Child and Family Interagency Team;

   c. Meet with the family and other significant individuals in the family's support network on an ongoing basis to plan and promote successful implementation of the ITP and to guide and encourage their participation in strategies to attain the prioritized outcomes identified in the ITP.

3. Monitoring the treatment plan with child and family participation to determine the adequacy and sufficiency of services and supports, goal attainment, need for additional assistance and continued appropriateness of services and goals;

4. Documentation of all aspects of Targeted Case Management services as they relate to an individual child, including case openings, participation in assessments, plans, referrals, progress notes, contacts, rights and grievance procedures, discharge planning, and case closure.

All Targeted Case Management activities may be performed by an individual with the required bachelor or Master's level provider qualifications with the exception of certain assessment and planning activities which must be performed by an individual who is a qualified mental health professional. Specifically, those functions are diagnostic activities, critical incident assessment and planning, and final approval and authorization of services and supports in the ITP.

Service Specifications

Targeted Case Management services should be provided at appropriate times and places to accomplish the desired outcomes which accommodate child and family choice and activities. Intensive Targeted Case Management service specifications include:

- A case manage should be assigned to eligible TCM recipients within 48 hours of being accepted for service. Documentation in the child or youth's record should reflect adherence to this time frame. (The record shall indicate the reasons why a TCM was not assigned within 48 hours, should this condition occur);

- TCM workers that bill a disproportionately number of units of service per week for one individual should document need consistent with ITP. Current edits is the system: no more than eight (8) hours per day, and no more than twenty-four (24) hours per month;

- The Targeted Case Manager's travel time to and from activities is billable to Intensive Targeted Case Management. The statutory definition of Intensive Targeted Case Management services does not include physically escorting a child to scheduled appointments. As a result, any time a child or family member accompanies the TCM worker in the car, the TCM cannot bill for their travel time. In addition, transportation is not a billable activity even if otherwise allowable TCM activities are occurring during the time in a vehicle. If a family has an ongoing transportation problem that impacts the child's ability to receive services, the family support team should address this need on the individualized treatment plan. POS case management is an option for billing when an unplanned transportation crisis occurs with the child/family;

- Targeted Case Managers should be available a substantial number of hours that other agencies are open, as well as be available for interagency team meetings, staffing, and accommodating to the schedules of individuals and families (a combination of day and evening/weekend hours is expected);

- If the case manager is assigned other work responsibilities besides their case management responsibilities, provision should be made to maintain Targeted Case Management coverage, flexibility and continuity. In the case of an individual working half time as a Targeted Case Manager and half time as a clinician (e.g. outpatient therapist), separate caseloads have to be maintained;

- The Targeted Case Manager's role is supported by program administration, such that the role is viewed as an equal in the treatment team;

- Services must be planned by an interdisciplinary Child and Family Interagency team as <u>part</u> of the discharge plan from an inpatient, residential, or day treatment program. TCM services added following the discharge plan should be reviewed by an interdisciplinary team of individuals. Services must be planned with and approved by the parent, or legal guardian;

- An interdisciplinary team must review the treatment plan at a minimum every three months;

- Planning for Targeted Case Management services should be based upon efforts to reach the stated outcomes in the treatment plan. New or revised goals or objectives should be established as needed to achieve the stated outcomes. There should be no arbitrary limits on either the duration or intensity of Targeted Case Management services;

- Once stated outcomes have been achieved and maintained for a three-month period, a plan for termination of Targeted Case Management is to be developed with any recommendations for further services. This includes a plan for reentry into the system if necessary (e.g. crisis develops);

- The ITCM is a brokering model, therefore, if deemed necessary, the targeted case manager shall connect individuals with parenting support and skills development resources when appropriate as opposed to offering these services directly;

- The child's identified TCM worker is the only individual that is allowed to bill to the TCM fund code.

Case Load Size

A Targeted Case Manager's caseload shall assure adequate service to accomplish identified outcomes in the individualized treatment plan. Lower caseloads are indicated for this population of children and adolescents due to the substantial demands for interagency collaboration and focus on intensive contact with the family. Caseloads of no more than twenty (20) identified children are recommended. Caseloads may increase to twenty four (24) temporarily if four or more of the children in the caseloads are in an inpatient or residential facility, or transitioning out of Targeted Case Management services.

The Case Management team should minimally consist of a supervisor who is a qualified mental health professional and no more than seven Case managers. The team should function in a manner to provide continuity for children receiving Targeted Case Management services and their families, i.e. team members should be familiar enough with the caseload of other Targeted Case Managers on the team to effectively fill in for them when a staff member is on leave, or a staff vacancy exists. However, each individual receiving Targeted Case management services should have a stable, supportive relationship with a primary Targeted Case Manager who is responsible to monitor whether an individual's treatment needs are met.

General Limitations

The following general limitations apply to all Targeted Case Management services. All Targeted Case Managers should be familiar with these limitations and understand how they may impact service provision,

1. The service activity must be performed by an appropriate and qualified provider.

2. Social/recreational activities with clients and family are not billable to the TCM program. This includes such activities provided both one-on-one and in group situations such as general social outings into the community, often described as "monitoring the client's social skills and behavior in the community", going to movies, shopping, sporting events, museums, etc. Often these activities are described as "rewards" for children and youth provided to incentivize progress. While these types of activities may be an important component in the overall treatment plan, they are not reimbursable under the TCM program. If an alternative funding stream such as POS case management is utilized to pay for these activities, the treatment plan should address how family dependency on this type of paid reinforcement will be avoided as well as address the family's own means for continuing it.

3. Direct services and clinical interventions are **not** billable activities to Medicaid under the TCM program. "Direct service: is defined as clinical interventions such as: coaching, teaching and modeling skills and behaviors for children and parents, crisis intervention, medication management, individual and family counseling, ongoing individual skill development such as parenting, anger management, and appropriate disciplining methods. While these activities may be an essential component of an individualized treatment plan, they are not covered services under the TCM Medicaid program.

   If the child/youth is eligible for enrollment in the Community Psychiatric Rehabilitation (CPR) program, he/she may be placed in that program and appropriate direct services and interventions (coaching, teaching, and modeling skills and behaviors) billed to Medicaid as Community Support.

   If the child/youth is not eligible for enrollment in the CPR program, these activities must be billed to another appropriate service on the providers POS contract and paid with state general revenue dollars.

4. The preparation time for delivering direct services is not a billable service under TCM. Examples include: developing behavioral intervention/behavior modification plans; copying information, skills sheets, and exercises from parenting and child development resources for the purpose of using them in teaching, coaching, modeling, skill building, or role playing interventions with children and parents.

5. All TCM services must be individualized and based on identified problems documented in an assessment and treatment plan. Time spent gathering general health information and sending it to all clients on a TCM's caseload, regardless of whether the assessment and treatment plan identified the issue for each child is not a billable TCM activity. An example of this might be copying an article on the warning signs of holiday depression, and mailing it to every client and family on a caseload.

6. Routine reviews of the case record to insure that all the paperwork is complete and in order is not a billable Medicaid service. A chart review for a specific purpose leading to an allowable activity, such as the development of revision of a treatment plan, or prior to writing a progress report to another agency is a billable service under TCM. Chart

review would also be proper for a new case manager who had the child transferred to their caseload, in order to become familiar with the case.

7. A generalized peer review of charts to check if documentation is up to date, releases are signed, etc., is not an activity billable to the TCM program. Generalized record reviews/peer chart reviews are a quality assurance type activity and are not reimbursable by Medicaid.

8. A case manager talking to another case manager about a child and documenting the conversation is not a billable TCM activity unless there is a planned change in the responsible case manager from one to the other. In this limited situation, it would be appropriate for a brief amount of time to be spent for the expressed purpose of informing the new case manager about the case. In the case of billing, the TCM worker that is the child's identified TCM at the time of the conversation, is able to bill.

9. Time staff spends attending workshops, in-services, and training sessions on generalized staff development topics and for looking up information on the internet or other media that would assist the staff person is gaining insight/professional knowledge to better serve a child or group of children are not billable activities under the TCM program.

10. Rounding practices can be applied when no single event with a person adds up to a billable unit. If multiple events occur in a single day with a single client, the total time spent in a day should be added first, and appropriate units of service billed (Example, five different 10 minute activities are added for a total time of 50 minute4s in one day, and 3 units of service are billed.) This does not preclude each separate activity being documented in a progress note that meets all the minimum requirements (activity description, time of service, location, etc.).

11. All other payers and third party insurance must be billed prior to billing DMH when applicable.

12. Services are not eligible for federal reimbursement when provided to General Relief Medicaid recipients.

13. If a child is hospitalized in a psychiatric inpatient hospital for treatment of a psychiatric disorder, TCM services may be billed to Medicaid only during the 30 days prior to discharge from the hospital. It is expected that the TCM worker will maintain contact with the child/family as well as hospital staff for purposes of family/community reintegration. TCM services may not duplicate services provided by the inpatient hospital facility.

14. Targeted Case management services, as clinically necessary, may be provided and billed to Medicaid on the day of admission and the day of discharge from the hospitalization in an inpatient bed for the treatment of a psychiatric disorder.

15. If a child is hospitalized for physical health care problems, TCM services may be billed as appropriate.

16. TCM services may be provided and billed to Medicaid on the day of admission and the day of discharge from a hospitalization.

17. If a child is placed in a residential facility for treatment of a psychiatric disorder, TCM services may be billed to Medicaid the entire time the child is in residential. It is expected that the TCM worker will maintain contact with the child during the residential stay for purposes of overseeing the transition process and coordinate community-based services as the child accesses the options available in the system of care. The specific residential treatment center as well as the child's clinical profile and support system should be considered by the CMHC when determining the kind of contact (face to face or by phone) and frequently of contact that is maintained. The CMHC is responsible for fulfilling the case management functions for a child in an out of home placement as per the Administrative Agency Supported Community Living Out-Of-Home Placement guidelines.

18. Services are not covered by Medicaid for individuals residing in a jail or detention facility. As the continuity of provision of Targeted Case Management is essential to achievement of the desired outcomes, TCM services should continue while the child is placed in a detention facility and billed to POS case management.

19. Services are not covered for persons who are residing in a nursing facility.

Service Unit

A unit of service is on quarter hour (fifteen minutes).

Rates

A two-tiered POS rate structure has been developed for services billed as Intensive Targeted Case Management based on the educational level of the Intensive Targeted Case Manager providing service to an individual. These services will be paid at either the standard Master's Level rate or the standard Bachelor's Level rate.

Billing and Reimbursement

State-operated providers enter TCM services into the CIMOR system, and invoices are created to submit claims to the MO HealthNet Division for payment.

Contracted community based providers bill TCM services to the DMH POS system for individuals who do not have Medicaid eligibility.

Contracted community based providers bill TCM service to MO HealthNet for individuals who have Medicaid eligibility. MO HealthNet processes the claims and forwards the claim information to DMH.

All payments for TCM services are made to contracted community based providers by the Department of Mental Health.

Administrative Lock-In. Some Medicaid recipients are restricted or "locked in" to authorized Medicaid providers of certain services to aid the recipient in proper utilization of the Medicaid program. This restriction applies only to the types of provider services listed on the Medicaid card.

Documentation

A complete clinical service record shall be kept for each child or youth receiving Child and Family Targeted Case Management services which includes identifying information, assessment information, an ITP, quarterly reviews of the plans, progress notes, service delivery documentation, updates regarding the child's response to support services, correspondence regarding the child, and discharge summary information, when applicable. Maintenance and retention of the clinical record shall be the responsibility of the provider agency.

An assessment as per 9 CSR 10-7.030 shall be completed if the child is being admitted for services to the agency and TCM will be one of the services provided. An ongoing annual assessment is not required under the TCM program. An initial ITP shall be developed at the time the child is admitted into the case management program. The treatment plan shall be in compliance with 9 CSR 10-7.030. An interdisciplinary team must review and update the ITP at a minimum of every three months.

The clinical evaluation components of the evaluation including the mental status, diagnosis and diagnostic impressions must be completed by a QMHP. Bachelor's level TCM staff may arrange, coordinate, and gather information for the psychosocial history component of the assessment but their work must be reviewed and verified by the QMHP.

When an individual is discharged from Targeted Case Management services, a discharge summary as per 9 CSR 10-7.030 shall be completed and should be inclusive of a plan for re-entry into the mental health service delivery system, if appropriate. (Note that the initial and closing diagnosis refers to the diagnosis per the QMHP.)

All services paid for by the Department (including Purchase of Service case management) and by Medicaid must be clearly and accurately documented in the case record, and contain at a minimum the elements required in program and state regulations. These elements include:

- Client name,
- Date of service,
- Place of service (location),
- A description of the activity/intervention,

- The relationship of the activity to the treatment plan,
- Signature,
- Title,
- Credentials of the person who performed the service,
- The exact time the service was delivered.

The exact time of the service must accurately reflect the actual time spent on the activity. All staff involved in delivering services paid for by DMH and Mo HealthNet Division (MHD) must be trained and educated with respect to the Federal False Claims Act and the consequences of reporting billing information which result in fraud and abuse of federal health care programs. Knowingly documenting more time than was actually spent performing an allowable activity is a violation of the Federal False Claims Act and subject to appropriate penalties.

While documentation time is billable to the TCM program the same rules apply as with any other billable activity. The exact clock time must be included n the progress notes; and, there must be a reasonable relationship between the progress note and the amount of time billed. All documentation must reflect the actual time spent on the activity for each child's case. Blocks of time spent writing progress notes, and then the time divided equally among all the children involved is not an appropriate Medicaid billing practice.

The time spent writing a progress note documenting the documentation of an allowable service is **not** a billable service to TCM. For example, it is not appropriate to deliver an allowable service on a Monday, write a progress note documenting that service on Tuesday, write a progress note on Wednesday documenting the time spent writing the note on Tuesday, and then, subsequently, billing for the time spent writing the progress note on Wednesday.

Progress notes must be individualized to each activity as opposed to prescriptive documentation with minor changes in content.

The progress notes must be legible and clearly describe the intervention. The note should support the billings, as well as reflect the care provided and progress with the child/family. Any person from a supervisor or QA officer, to a state or federal auditor, should be able to read the content of the progress note and easily discern the activity that occurred.

The identified child's record should include documentation of phone contacts of varying lengths of time, some resulting in billable activities, and some not. All billable activities must include the actual clock time of the activity. Eight (8) minutes is the minimum time needed to be spent on an activity in order to bill one unit of TCM service.

Travel time must clearly be described in the progress note, separate from direct contact time.

Documentation should be completed in a timely manner. The code of state regulations for the MO HealthNet Division state that documentation must be completed in a contemporaneous manner, and defines this term as meaning within 72 hours of service delivery. The Department of Mental Health has filed a rule amendment that reflects and supports the same language. In no case should a service ever be billed to either the Department or to Medicaid that has not been

documented by the provider. All providers must have effective processes in place to assure compliance with this requirement.

Retention of Records
The contractor shall retain all records pertaining to TCM for six (6) years after the close of the contract year unless audit questions have arisen with the six year limitation and have not been resolved. All records shall be retained until all audit questions have been resolved.

Training Standards

Staff Qualifications and Training Requirements

Targeted Case Managers will be employed by the Division of Comprehensive Psychiatric Services and by administrative entities of the Department of Mental Health designated in Missouri's Comprehensive Mental Health Plan as eligible recipients of funds under 205.975 through 205.990 RSMo. All Targeted Case Managers must meet at least the following minimum experience and training as per the State Case Management Plan under Title XIX of the Social Security Act:

> A graduate from an accredited four (4) year college or university with a specialization in Sociology, psychology, social work, or closely related fields and at least one (1) year of full-time equivalent experience in working with children and families.

Supervisors: Targeted Case Management Supervisors must meet the following qualifications as per the State Case Management Plan under XIX of the Social Security Act:

> Graduation from an accredited college or university with a master's degree in social work, psychology, counseling, psychiatric nursing or closely related field who have at least two (2) years of full time equivalent experience in the treatment and assessment of children.

TCM Supervisors are responsible for training newly employed Targeted Case Managers in the strengths based TCM model of service. The agency should provide adequate orientation and training to enable staff to perform their jobs effectively.

In addition, supervision is to be provided, individualized to the needs of the Targeted Case Manager, to assure that the Targeted Case Manager has skills and competencies to support and assist the child in attaining desired outcomes. Supervision should be competency focused and include:

- detailed review of specific child situations
- exploration of resource acquisition strategies for a child/family
- goal setting for a child/family
- development of advocacy strategies for a specific family;
- evaluation of needed changes to effectively support a child receiving services and their family.

Activities that occur during normal supervisory meetings that do not relate to review of specific child cases such as discussions about scheduling, time management, staff development, oversight of documentation and reporting of information, etc. are not billable components of TCM. Only the time spent talking about specific child cases for the purposes of reviewing progress and monitoring the effectiveness of the treatment plan is billable as TCM, when it is appropriately documented. Routinely billing the entire time spent in scheduled supervision meetings, without removing the non-client specific time, is not appropriate.

It is strongly recommended that the supervision process at each agency include a review of a sufficient amount (up to 100% if necessary) of progress notes for each TCM worker to insure that allowable TCM services are provided and that significant billing amounts have adequate descriptions of the activity.

Other

Outcomes

Increasingly, focus on outcomes has become a critical component of evaluation of the clinical and financial effectiveness of Targeted Case Management and other mental health services. The Division has identified the following general outcome areas as key to improved quality of life for children and adolescents with serious emotional disturbance or who are experiencing an acute psychiatric condition:

1. Increased home/community inclusion and tenure with fewer penetrations into more intensive services;

2. Progress from more restrictive educational setting to least restrictive and;

3. Reduction or elimination of the child's involvement with the juvenile justice system as measured by decreased referrals and/or court involvement, unless continued juvenile justice system involvement is clinically indicated.

Other outcome measures for consideration by the Targeted Case Manager are increased social supports, improved family and peer relationships, improved physical health, increase in meaningful activities, and successful award of eligible entitlements.

Quality Management

All Targeted Case Management providers must develop appropriate mechanisms and policies which support the provision of high quality services which are individualized to meet the unique service and support needs of children and youth with serious emotional disturbance or who are experiencing an acute psychiatric condition. Individuals and their families should be involved in the evaluation process and the evaluation should include measures of child and family satisfaction.

As an example, in general, service duration is expected to change based on client need, nature of the activity, or other circumstances. Staff time reported in a repetitive fashion for a particular child or group of children may be an indicator of either inappropriate and unnecessary services being delivered, or health care fraud. Providers should be integrating management reports of billing patterns into the supervisory process as part of their corporate compliance and quality assurance efforts.

The provider's corporate compliance plan should include how TCM workers will be educated and training regarding TCM duties as well as specific oversight activities that the agency will utilize to monitor and detect fraud and abuse of this service.

In addition to using quality improvement technologies and examining outcomes as a measure of effectiveness, each agency providing Targeted Case Management must develop mechanisms for periodic feedback related to consumer satisfaction with the Targeted Case Management services they receive.

Standards and Non-Discrimination

All providers must comply with the non-discrimination provisions of Title VI of the Federal Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Americans with Disabilities Act.

Children and Youth Enrolled in CPR

Certain activities can be billed to the Medicaid TCM option for children and youth enrolled in the CPR program. When a child/youth is enrolled in CPR in the Rehabilitation level of care, TCM can be billed for:

- Direct face to face contacts with all collateral contacts, including but not limited to: parents/caretakers, and other agencies (school, Children's Division (CD), Division of Youth Services (DYS), Juvenile Justice, medical/behavioral health)
- Phone contact with all collateral contacts, including but not limited to: parents/caretakers and other agencies (school, CD, DYS, Juvenile Justice, medical/behavioral health)
- These persons/agencies must be identified on the Treatment Plan and the intervention must relate back to a goal on the Treatment Plan.
- These activities are billable only if they are allowable TCM functions authorized in the State Plan. Direct clinical interventions with parents or children are not billable to TCM.

What cannot be billed as TCM for a child/youth enrolled in CPR in the Rehabilitation level of care is:

- Travel time to and from any contacts
- Documentation time
- Time spent developing assessments, treatment plans, and treatment plan reviews. Those activities are reimbursed in the bundled Initial and Annual Assessment service.

When a child/youth is enrolled in CPR in the Intensive level of care, TCM cannot be billed. The per diem rate for Intensive level CPR includes reimbursement for all such activities.

When a child/youth is enrolled in CPR in the Maintenance level of care, allowable TCM activities may be billed to the TCM option, but Community Support may not be billed. The Maintenance level of care in CPR is intended for children with minimal clinical needs beyond the need to have medications reviewed periodically by a physician. Children who have need for direct clinical interventions including coaching, teaching, and modeling skills and behaviors for children and parents should be served in the Rehabilitation level of care and those types of interventions billed as Community Support.

Appropriate staff can be reimbursed for completing the CAFAS by billing up to two (2) 15 minute units of Targeted Case Management.

Appendix A

Glossary

Individual Treatment Plan: A plan of action developed by an agency or discipline as a result of an assessment to alleviate or ameliorate symptoms of an identified need. The treatment plan must include the scope, frequency, and duration of services.

Child and Family Interagency Team: Representatives of all agencies and/or providers who are involved in providing services to the child and family. This team should include the parent, foster parent or guardian and may include other individuals who are significant in a child's life.

Interdisciplinary Team: A group of individuals that, relying on their individual and combined areas of expertise, function in a collaborative and integrative manner to develop a treatment plan to access/provide services as outlined by that plan.

Supports: Are those activities and technological program components which promote the ability of the family(ies) to maintain youth in their natural living arrangements. TCM's when appropriate should be brokering these supports for the child/family.

Example: Providing peer companions for role modeling purposes.

Arranging and obtaining supportive communication devices.

Arranging for needed home convenience items such as washers and dryers.

Assist in arranging transportation for medical appointments or leisure activities.

Payment of membership fees to generic community services as the Boy's Club, YMCA, and etc.

Arrange for the provision of homemaker services to promote parenting approaches.

Funding sources such as Wrap-Around

Life Domain Needs: Are areas of basic human needs that almost everyone experiences. These are: 1) Residential (a place to live); 2) Family or surrogate family; 3) Social (friends and contact with other people); 4) Educational and/or Vocational; 5) Medical; 6) Psychological/Emotional; 7) Legal (especially for children with juvenile justice needs); 8) Safety (the need to be safe); and other specific life domain areas such as cultural/ethnic needs or community needs.